Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TX 78265

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-5990-01

MFDR Date Received
FEBRUARY 9, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting medical dispute resolution on the following 10 codes presented to the insurance carrier for preauthorization. Each code was preauthorized by the insurance carrier. The said procedure was performed and now denial of payment by the insurance carrier…Each one of these codes has been performed as documented in the operative report and has not been funded."

Amount in Dispute: $2,884.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Detailed MDR review again supports previous reviews & payment as correct, with no additional reimbursement due for 2/13/2008 surgical procedures."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2008	CPT Code 21899-99	$500.00	$0.00
	CPT Code 63075-51	$768.35	$0.00
	CPT Code 63076	$293.71	$0.00
	CPT Code 62291	$91.56	$0.00
	CPT Code 62291-59	$91.56	$0.00
	CPT Code 22326-59	$804.69	$0.00
	CPT Code 22328	$334.20	$0.00
TOTAL		$2,884.07	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

- W1-Workers Compensation State Fee Schedule Adjustment.
- 97-Payment adjusted because the benefit for this service is included in the accordance with multiple surgical procedure rules and/or guidelines.
- 285-Please refer to the note above for a detailed explanation of the reduction; 63075 & 63076 diskectomies not separately reportable with 63081 & 63082 per NCCI Edits; op report documents customary descriptors of all procedures on which Edits are based; no exception warranted.
--69990 miscrodiscection not separately reportable with any other procedure this op session per NCCI Edits; no modifier exception allowable.
--20938 autograft harvest via separate incision
--62292 X 2 discogram not separately reportable with other procedures this op.
- 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery: Endocrine, nervous, eye and ocular adnexa, auditory systems procedure (60000-69999) has been disallowed.
- B12-Services not documented in patients medical records.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 275-The charge was disallowed; as the submitted report does not substantiate the service being billed.

Issues

1. Is the requestor entitled to reimbursement for CPT code 21899-99?
2. Is the requestor entitled to reimbursement for CPT code 63075-51?
3. I Is the requestor entitled to reimbursement for CPT code 63076?
4. s the requestor entitled to reimbursement for CPT code 62291?
5. Is the requestor entitled to reimbursement for CPT code 62291-59?
6. Is the requestor entitled to reimbursement for CPT code 22326-59?
7. Is the requestor entitled to reimbursement for CPT code 22328?

Findings

1. The Requestor billed CPT code 21899-99 –"Unlisted procedure, neck or thorax."

   The requestor appended modifier "99-Multiple Modifiers" to CPT code 21899.

   According to the explanation of benefits, CPT code 21899-99 was denied based upon reason codes "B 12 and 275."

   On April 2, 2008, the Requestor wrote "Code 21899-99 for examination under anesthesia and pain study, a fair and reasonable charge of $500 was made and no payment whatsoever from your office with reasoning 'included in another payment.' This is an erroneous conclusion…This is at the request of the treating physician and is to be used for maximal medical improvement and impairment rating methods…"

   The Respondent wrote in their reconsideration of bill "Provider states billed for EUA & pain study; states denial reason 'included in another pmnt' is erroneous…Actual denial reason as evidenced on provider-submitted

EOB copy, B12 'not documented in patient's records.'…This O.R. exam & assessment is a customary component of the primary procedure corpectomy/diskectomy/arthrodesis; is necessary for the successful outcome of the primary procedure, & does not represent a significant, separate unrelated procedure. Impairment rating is not requested or documented."

The requestor did not submit a copy of the examination under anesthesia and pain study to support the billed study. Therefore, the respondent's denial based upon reason codes "B12 and 275" are supported.

Furthermore, 28 Texas Administrative Code §134.202 (c) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:
(1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.
(2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L:

(A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

(B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or

(C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

28 Texas Administrative Code §134.202 (c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

CPT code 21899 does not have a listed relative value unit or payment assigned by Medicare or Texas Medicaid and/or the carrier did not assign a relative value; therefore, this code is subject to fair and reasonablereimbursement.

28 Texas Administrative Code §134.1 which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $500.00 for CPT code 21899 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

2. CPT code 63075 is defined as "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace."

   The requestor appended modifier "51-Multiple Procedures" to CPT code 63075.

   The respondent denied reimbursement for CPT code 63075 based upon reason codes "97 and 903."

   28 Texas Administrative Code §134.202 (b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section".

   On the disputed date of service the requestor billed the following codes: 99220, 21899-99, 63075-51, 63076,

69990-59, 20938, 62291-51, 62291-59, 22326-59, 22328-59, 63081, 63082, 63082-59, 22554-51, 22585, 22851, 22851-59, and 22845-51.

Per CCI edits, CPT code 63075 is a component of procedure codes 63081 and 63082. The requestor used modifier "51" to differentiate the service. This modifier does not support a separate distinct service. As a result, reimbursement cannot be recommended.

3. CPT code 63076 is defined as "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)."

   This code is used in conjunction with CPT code 63075 for the additional level, therefore, it is bundled to CPT codes 63081 and 63082. As a result, reimbursement cannot be recommended.

4. CPT code 62291 is defined as "Injection procedure for discography, each level; cervical or thoracic."

   The requestor appended modifier "51-Multiple Procedures" to CPT code 62291.

   According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "97 and 903."

   Per CCI edits, CPT code 62291 is a component of CPT codes 63075 and 22554. A modifier is allowed to differentiate the service. The requestor used modifier "51" to differentiate the service. This modifier does not support a separate distinct service. As a result, reimbursement cannot be recommended.

5. CPT code 62291 is defined as "Injection procedure for discography, each level; cervical or thoracic."

   The requestor appended modifier "59-Distinct Procedural Service" to CPT code 62291.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "97 and 903."

   Per CCI edits, CPT code 62291 is a component of CPT codes 63075 and 22554. A modifier is allowed to differentiate the service. The requestor used modifier "59" to differentiate the service. The documentation does not support the use of modifier 59. As a result, reimbursement cannot be recommended.

6. CPT code 22326 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical."

   The requestor appended modifier "59-Distinct Procedural Service" to CPT code 22326.

   According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "B12 and 275."

   The operative report does not support a posterior approach; therefore, does not support billed service. As a result, reimbursement cannot be recommended.

7. CPT code 22326 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical."

   The requestor appended modifier "59-Distinct Procedural Service" to CPT code 22326.

   According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes "B12 and 275."

   The operative report does not support a posterior approach; therefore, does not support billed service. As a result, reimbursement cannot be recommended.

8. CPT code 22328 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure."

According to the explanation of benefits, the respondent denied reimbursement for this service based upon reason codes “B12 and 275.”

The operative report does not support a posterior approach; therefore, does not support billed service. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	7/19/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.